

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004426</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>ADDISON PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2244 Q AVE NEW CASTLE, IN 47362</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: September 8 &amp; 9, 2014</p> <p>Facility number: 004426 Provider number: 004426 AIM number: N/A</p> <p>Survey team: Angel Tomlinson, RN-TC Barbara Gray, RN</p> <p>Census bed type: Residential: 25 Total: 25</p> <p>Census Payor type: Other: 25 Total: 25</p> <p>Sample: 7</p> <p>Addison Place was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 09/10/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE